Submission No 34

INQUIRY INTO DRUG AND ALCOHOL TREATMENT

Organisation: National Drug and Alcohol Research Centre

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National Drug and Alcohol Research Centre

Submission to NSW Inquiry into AOD treatment

We thank the committee for the opportunity to provide comments to the Inquiry into drug and alcohol treatment. The National Drug and Alcohol Research Centre is an internationally recognised research centre that has an overall mission to conduct and disseminate high quality research and related activities that increases the effectiveness of responses to alcohol and other drug related harm. The areas of work where we seek to achieve outcomes are:

- The development and testing of new and existing interventions
- Improving the understanding of the nature and extent of Alcohol and other Drug (AOD) use and harm
- Building research capacity in the sector
- Conducting policy research
- Communicating the outcomes of research

Terms of reference # 1: The delivery and effectiveness of treatment services for those addicted to drugs and/or alcohol, including naltrexone treatment, with reference to the welfare and health of individuals dependent on illicit drugs and the impact on their families, carers and the community having regard for:
(a) The need for appropriate human research, ethics and Therapeutic Goods Administration approval for use of new treatments in clinical trials
(b) The current body of evidence and recommendations of the National Health and Medical Research Council

Drug and alcohol treatment must be evidence based and delivered by appropriately trained and qualified health professional. Treatment needs to be delivered across a variety of settings (including specialist inpatient facilities, outpatient facilities, within primary care settings, in outreach settings and so on). Treatment must also be individually tailored to the client's needs and this/her own goals at that time. Alcohol and drug problems are an example of a chronic relapsing condition, not dissimilar to asthma or diabetes and they require continuity of care across the lifespan in many cases. Longer treatment is better treatment and keeping people in treatment is essential in assisting them to achieve their goals. Evidence-based treatment services must be complemented with harm reduction services, which reduce the harms for those who use drugs. Harm reduction services with proven efficacy include needle syringe programs, supervised injecting centres and naloxone distribution programs.

NDARC has extensive experience in the conduct of clinical trials of various medications for the treatment of both opioid dependence and alcohol dependence. These medications include methadone, naltrexone, and buprenorphine. Naltrexone is an opiate antagonist which has no psychoactive effects but blocks the opioid receptors effectively blocking the positive effects of heroin, if heroin is consumed. Normally taken daily by mouth, the implant form inserted under the skin delivers blocking levels of the drug for a prolonged period of time ranging from weeks to months. In the USA and Russia the long-acting duration is achieved through an intramuscular depot injection which lasts about a month.

In 2011 the National Health and Medical Research Council undertook a review and concluded that naltrexone implants should "remain an experimental product and should only be used within a research setting". The review is available online: http://www.nhmrc.gov.au/media/notices/2011/naltrexone-implant-treatment-opioid-

dependence-literature-review. The National Health and Medical Research Council remained unconvinced of the safety or effectiveness of the implants and was not persuaded that the long-term overdose risk reduction was maintained after treatment has ended. They noted very few RCTs on this question.

In light of the available data, depot naltrexone has shown some positive findings (1), whereas the implant naltrexone remains unproven.

Terms of reference # 2: The level and adequacy of funding for drug and/or alcohol treatment services in NSW.

The funding models for drug and alcohol treatment in NSW are less than transparent, due to multiple different funding bodies and funding arrangements. In this light, it is not possible to assess the adequacy of funding levels given the absence of accurate information about the current extent of funding. Nevertheless, it is apparent that there are many gaps in services for those in need. This can be seen in the waiting lists associated with entry into treatment; the poor match between treatment needs and types of treatment provided; and the barriers to treatment entry (such as costs associated with methadone dispensing).

On the positive side, NSW does provide the full array of known effective and cost-effective interventions for alcohol and drug problems including harm reduction services, detoxification (withdrawal) services, psychosocial support, counselling and case management; therapeutic communities and other forms of residential rehabilitation.

The DA-CCP model, being led by NSW Health, which is due for completion in April 2013, will provide a nationally consistent approach to assessing the funding requirements for a sufficient level of alcohol and drug treatment. NSW government can use the model to develop projections about the extent of resources that would be required: including the numbers and types of staff, the numbers of outpatient/ambulatory treatment places; the number of beds and the costs for treatment associated consumables (medications, diagnostic tests and so on). This will be an invaluable tool to assess the level and adequacy of current NSW treatment funding – but requires that current levels of funding are known.

Terms of reference # 3. The effectiveness of mandatory treatment on those with drug and/or alcohol addiction, including monitoring compliance with mandatory treatment requirements

To date NDARC has not carried out any specific work on Mandatory Treatment, and will only make some brief comments on this issue. It is widely recognised that coercion plays a significant role for many people entering treatment. Such coercion may be by an employer, a spouse or other family member, probation officer or court order. There are data available to indicate that the mode of entry into treatment does not affect outcome as much as the structure of the type of treatment that is accessed. However that being said there is no good experimental research on mandated treatment to indicate it effectiveness or cost effectiveness. There is some evidence from the studies of health professionals and other professionals that mandated monitoring and required treatment compliance is associated with good outcomes. But such work has not been subject to Randomised Controlled Trials.

Terms of reference # 4. The adequacy of integrated services to treat co-morbid conditions for those with drug and/or alcohol addiction, including mental health, chronic pain and other health problems

Mental and substance use disorders account for more years of life lost due to disability than any other disorders (24% of burden) and are second only to cardiovascular disease and cancer as leading causes of disease burden. The top 10 causes of burden of disease in young Australians (15-24 years) are dominated by mental and substance use disorders (2). Every year alcohol and drugs conservatively cost the Australian community $23.5billion (3). Governments take the lead in managing this problem, with investments in health, community and law enforcement interventions across Australia estimated at $3.2billion p.a. (4). Comorbidity is common with *25-50%* of people experiencing more than one disorder (5). Once both mental and substance use disorders have been established the relationship between them is one of mutual influence with both conditions serving to maintain or exacerbate the other. Such comorbidity leads to poor treatment outcomes and severe illness course (6,7). In the longer term, mental disorders and substance use disorders are themselves associated with increased rates of CVD and cancer (8). CVD and cancer are the leading causes of mortality for people with a history of mental health treatment. Average life expectancy is 20-30 years shorter among people with mental or substance use disorders (9) compared to those without such problems, with the last 10 years of life spent living with chronic illnesses (7). Despite significant public concern leading to a major government initiative (National Comorbidity Initiative) comorbid mental health and substance use remain a major cause of disability among young people and, in the longer-term, are associated with poor quality of life and early mortality at the end of life.

Australia has some excellent resources including clinical treatment guidelines which have been disseminated to over 9000 clinicians (10, 11) (see www.comorbidity.edu.au) and a new NHMRC Centre of Research Excellence in Mental Health and Substance Use but new knowledge and translation is critical. Both of these are NSW-led initiatives through NDARC, which places NSW at the forefront of responses for comorbidity.

Currently the issue of Chronic Non Malignant Pain and the use of opioids indicates that there has been a substantial rise in the use of Oxycodone and other prescription pharmaceuticals resulting in a rise in drug related deaths from Oxycodone (12). Work in Tasmania indicates that this a substantial problem and the report by Mattick et al (2012) has recommended that Real Monitoring of Prescribing of such drugs be put in place. The National Opioid Pharmaceutical Strategy recommends the need for training of all health care professionals in good pain management strategies. The challenge of the projected growth in the older adult population over the coming two decades requires considerable adaptation of existing service frameworks if they are going to respond appropriately to the needs of this growing population.

Terms of reference # 5. The funding and effectiveness of drug and alcohol education programs, including student and family access to information regarding the legal deterrents, adverse health and social impacts and the addictive potential of drugs and/or alcohol

A report on the type and efficacy of Australian school-based prevention programs for alcohol and other drugs has been undertaken (13). The following sources were searched, Cochrane, PsychInfo and PubMed databases and additional materials were obtained from authors, websites and reference lists. Programs developed and trialled in Australia that address prevention of alcohol and other drug use in schools were included. Eight trials of seven intervention programs were identified. The programs targeted alcohol, cannabis and tobacco and most were based on social learning principles. Five of the seven intervention programs achieved reductions in alcohol, cannabis and tobacco use at follow-up.

Existing school-based prevention programs have shown to be efficacious in the Australian context. However, there are only a few programs available, and none have been widely implemented. This is critical, given that substance use is such a significant public health problem. The findings challenge the commonly held view that school-based prevention programs are not effective. Work by NDARC researchers, using Climate Schools program has shown it to be effective as a prevention program (14, 15). The newer internet delivered programs have scalability so that they can be broadly implemented. See www.comorbidity.edu.au and www.climateschools.com

Terms of reference # 6: The strategies and models for responding to drug and/or alcohol addiction in other jurisdictions in Australia and overseas, including Sweden and the United Kingdom

Other jurisdictions such as the UK and Sweden and EU have services of similar structure to those in Australia. Most are funded through a mixture of health and social services and attempt to develop strong links with the criminal justice system. Most aim to provide a wide range of stepped care approaches with rapid and brief interventions available on a broad basis. A mixture of psychosocial and pharmacological approaches are delivered and the balance of these approaches differs considerably across different EU countries. The EMCDDA has excellent online resources whichd ecsribe treatment services across all EU countries (see: http://www.emcdda.europa.eu/responses/treatment-overviews). All countries to an extent claim to aim to provide an integrated multi- model treatment approach. To the best of our knowledge there is no country that has a unique and specific model that we would recommend for particular attention. Sweden has a long history of compulsory treatment. This approach has been subject to simple descriptive evaluations but not to any rigorous experimental evaluation. It takes place in the context of a long historical deeply rooted temperance tradition and is not viewed as contentious within Sweden.

Terms of reference # 7: The proposed reforms identified in the *Drug and Alcohol Treatment Amendment (Rehabilitation of Persons with Severe Substance Dependence) Bill 2012*

NDARC has not undertaken on work on the evaluation of this recent legislation. NDARC emphasises the importance of undertaking rigorous experimental evaluation including cost effectiveness studies of such approaches. It is worthwhile noting that people with drug and alcohol problems should have recourse to full range of the mental health laws in order to protect and support them. However a major reservation should be maintained on the value of compulsory treatment until rigorous studies clearly demonstrate its effectiveness and cost effectiveness.

Contact details

If you would like any further information on the above or other matters that NDARC may be able to assist the Inquiry, please feel free to contact me.

Yours sincerely,

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